Department of Health
Child and Adolescent Mental Health Division

Performance Report

Performance Period January 2005-March 2005

Introduction

This report presents the third quarter of fiscal year 2005 (January 2005-March 2005) findings about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD). The data are based on the most current data available, and where possible are aggregated at both statewide and district or complex levels. Tracking and analysis of data provides information that allows CAMHD and stakeholders to determine how well, and how efficiently, CAMHD is delivering care and impacting child outcomes.

Data are presented for four major areas: Population, Service, Cost, and Performance Measures. Population information describes the demographic characteristics of the children and youth served by CAMHD. Service information is compiled regarding the type and amount of direct care services provided. Cost information is gathered about the financial aspects of services. Performance Measures, including Outcome data, are used to understand and track the quality of services over time and the performance of operations of the statewide infrastructure designed to provide needed supports for children, youth, and families. Outcomes are further examined to determine the extents to which services that are provided lead to improvements in the functioning and satisfaction of children, youth and families.

How Measures Are Selected

CAMHD continues to report on measures of interest to the Federal Courts regarding the sustainability of improvements that have been made in the children's mental health service system in Hawaii. These measures are:

1) CAMHD outcome and results components will be implemented (Benchmark 22),
2) CAMHD will have developed appropriate CSPs for all children whose care is coordinated by CAMHD (Benchmark 26),
3) Service gap analysis (unserved youth report) will document that no child will wait longer than 30 days for a specified service or appropriate alternative…CAMHD will document in the quality improvement reviews that appropriate referrals are being made (Benchmarks 33 and 54-deemed completed),
4) Personnel and Vacancy Reporting,
5) Benchmarks that describe complex-based service testing, and
6) Complaints (no Benchmark attached, reporting requested by the Felix Monitoring Project).

Pursuant to the Stipulation for Step-down Plan and Termination of the Revised Consent Decree, this report also presents data by Family Guidance Center for numbers of children and youth served by CAMHD, percentage of care coordinator positions filled, and percentage of youth served who have a Coordinated Service Plan. The remaining performance measures were added to the reporting requirements based on the submittal of the Hawaii Continuous Integrated Monitoring and Improvement Process dated August 2002.

CAMHD Performance Management System

Use of data to improve services and service delivery

The CAMHD Performance Management system allows CAMHD to examine performance and use information to make decisions about adjustments to its program. Performance data in CAMHD are tracked systematically across all aspects of service delivery and care. Services are monitored through tracking of trends and patterns found in utilization and satisfaction data, and examinations of practice and quality of services. This information helps determine how well the system is performing for youth, and how well youth are progressing. It is sensitive enough to ascertain if the system is performing better or worse for certain populations, and comprehensive enough to detect what aspects of care, and in what settings, problems may be occurring.

Further studies and special reports on the CAMHD population and services, including past editions of this report can be accessed at the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/resources/index.html.

In the quarter, there were two major external reviews of CAMHD's quality management systems. A validation review of selected performance measures was conducted by the Health Services Advisory Group, which is the Med-QUEST Division's External Quality Review Organization (EQRO) for monitoring compliance with the Balanced Budget Amendment (BBA-Medicaid Rules for Managed Care Organizations). This review examined CAMHD's ability to collect valid data that is the basis for reporting on its performance. Feedback of the site review indicated that all measures were validated, and no corrective actions were required.

In early April, the EQRO also conducted a focused review of standards that determine CAMHD's overall compliance with the BBA. Reviewed were standards for CAMHD's performance in:

- Describing its quality management program,
- A systematic process for quality monitoring,
- An active quality monitoring committee,
- A delegation program (CAMHD delegates primary source verification for credentialing of providers),
- Credentialing and re-credentialing of providers,
- A system for ensuring the rights and responsibilities for youth and families,
- Access and availability of services,
- Providing continuity of care, and
- Managing provider disputes and grievances.

Feedback received at the site review indicated strong performance across all requirements for maintaining an active quality management program and high-quality provision of services for children and families.

Data Sources

Data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through the Child and Adolescent Mental Health Management Information System (CAMHMIS). CAMHMIS produces data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data, FGC-specific reports and other special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

Population Characteristics

Population data presented here are for youth registered through the CAMHD Family Guidance Centers during the third quarter of fiscal year 2005 (January 2005-March 2005). In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,870 youth across the State, an increase of 77 from the previous reporting quarter (October 2004-December 2004), or a 4% increase in the total population. Increases in the registered population were experienced in all Family Guidance Centers with the exception of Maui FGC and Family Court Liaison Branch. Since the same period last year (January 2004-March 2004), CAMHD has experienced a 7% overall increase in its registered population.

The numbers of youth registered at each of the Family Guidance Centers during the third quarter (January-March 2005) are displayed in Table 1. The numbers for Kauai (KFGC) are for the Mokihana Project in total, which serves youth with both low and high intensity mental health needs. The largest population continues to be served on the Big Island through the Hawaii Family Guidance Center (HFGC). HFGC served 24% of the total CAMHD population during the quarter. The Leeward Family Guidance Center (LFGC) serves the largest population on Oahu, and 12.5% of CAMHD registered youth. The Family Court Liaison Branch (FCLB), which provides services primarily for incarcerated and detained youth, continues to serve the smallest registered population (2%).

Table 1. Population of Youth Registered by Family Guidance Center, FY 2005, Quarter 3 (January 2005-March 2005)

COFGC	LOFGC	MFGC	WFGC	HOFGC	HFGC	KFGC	FCLB
162	233	158	149	164	448	521	35

The total number of registered youth are described by four subgroups: (*i*) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (*ii*) youth who were in the process of having services arranged (new admissions), (*iii*) youth who received less intensive services through Mokihana on Kauai, and (*iv*) youth who were discharged at some time during the quarter. There is also a percentage of youth who receive intensive case management services only. Of the total number of registered youth, 1,014 had services that were authorized within the quarter.

Of the registered population (1,870), 159 youth (8.5%) were newly registered (had not previously received services) in the third quarter of fiscal year 2005. This represents an increase of 35 new admissions from the previous quarter (October 2004-December 2004). One hundred twelve (112) youth (6.0%) who had previously received services from CAMHD were reregistered, an increase from last quarter's readmissions of 108 youth. CAMHD discharged a total of 137 youth during the quarter, or 7.3% of the registered population. This is an increase in numbers, but a decrease in percentage discharged from last quarter's discharge of 181 youth, which was 10.1% of the registered population.

Of the 1,014 youth who had services authorized in the quarter, 61 were new admissions (6.0%), 47 repeat admissions (4.6%) and 42 discharges (4.1%). Because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size.

The average age of youth, age range and percentage of males versus females continues to be stable among the CAMHD population. The average age of registered youth in the reporting quarter was 14.2 years with a range from 3 to 20 years. The majority of youth, as seen in Table 2 were male (66%).

Gender	N	% of Available
Females	635	34%
Males	1,235	66%

Table 2. Gender of CAMHD Youth

The races of youth registered in the reporting quarter are displayed in Table 3. Beginning with this quarter, data are reported as race versus the previous reporting of ethnicity. CAMHD has begun collecting race and ethnicity data with categories that are in closer alignment with U.S. Census reporting.

Multiracial youth represented the largest racial group (63.5%), followed by White youth (16.5%), and then Native Hawaiian or Pacific Islanders (9.7%). Please note that race data was not available (no data entered) for 49.0% of youth registered. The Family Guidance Centers have not yet fully converted to the new methodology of capturing race and ethnicity data in the redesigned MIS registration module. Although race data is more available this quarter than last (61.6%), roughly half of registered youth do not have race data recorded.

Table 3. Race of Youth (Unduplicated)

Ethnicity	N	% of Available
American Indian or Alaska Native	1	0.1%
Asian	74	7.8%
Black or African-American	16	1.7%
Native Hawaiian or Pacific Islander	92	9.7%
White	157	16.5%
Other Race	8	0.8%
Multiracial	605	63.5%
Based on Observation	142	14.9%
Not Available (% Total)	917	49.0%

Subpopulations of youth who receive services through CAMHD are also involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 4). In the quarter, 9.7% were involved with DHS, 24.6% had a Family Court hearing during the quarter, and 7.0% were incarcerated at HYCF or detained at the Detention Home at some point during the quarter.

Table 4. Agency Involvement

Agency Involvement	N	%
DHS	181	9.7%
Court	460	24.6%
Incarcerated/Detained	131	7.0%
SEBD	454	24.2%
Quest	675	36%

Services to youth who are QUEST-eligible and have a Serious Emotional and Behavioral Disturbance (SEBD) occurs by virtue of a Memorandum of Agreement (MOA) with the Med-QUEST Division. Youth who were eligible for services through the SEBD process numbered 454 and were 24.2% of the registered population. This was a decrease of 113 youth in the SEBD category over the previous quarter (October 2004-December 2004). As previously discussed, CAMHD

has recently redesigned its CAMHMIS client registration module. During the conversion this data was derived from a different data source than past reports, and may reflect some variance.

QUEST-eligible youth who received services in the quarter were 36% of the population. The total number of QUEST enrolled youth increased from last quarter, when 638 youth with QUEST insurance were registered with CAMHD (35.6% of the registered population). QUEST-eligible youth may also be eligible for services through CAMHD because of their educational or court-ordered status.

Table 5. Diagnostic Distribution of Registered Youth

Any Diagnosis of	N	%
Disruptive Behavior	743	43.8%
Attentional	735	43.4%
Mood	617	36.4%
Miscellaneous	427	25.2%
Anxiety	321	18.9%
Substance-Related	257	15.2%
Adjustment	201	11.9%
Mental Retardation	36	2.1%
Pervasive Developmental	28	1.7%
Multiple Diagnoses	1,209	71.3%
Ave. Number of Diagnoses	1.9	

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 5). The reported percentages may exceed 100% because youth may receive diagnoses in multiple categories.

The top three diagnoses of youth with registered services in the quarter were Disruptive Behavior disorders (43.8%), Attentional disorders (43.4%), and Mood disorders (36.4%). In previous quarters, the diagnostic breakdown was fairly consistent. This quarter, there was a slight increase in the number of youth identified with Disruptive Behavior disorders, representing the first quarter that there have been more youth with Disruptive disorders than those with Attentional disorders.

Miscellaneous diagnoses accounted for 25.2% of youth in the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control, learning and eating disorders.

The majority of youth in the CAMHD registered population have co-occurring, or more than one diagnosis. In the reporting quarter, 71.3% of registered youth had more than one diagnosis, with an average of 1.9 diagnoses per youth. This is a slight decrease from the previous quarter (October 2004-December 2004) when 73.1% had co-occurring disorders. For those with services authorized, the percentage of youth with multiple diagnoses was even higher (76.8%) with an average of 2.2 diagnoses per youth, which means that over three quarters of youth that received services within the CAMHD array in the quarter had co-occurring diagnoses. The co-occurring diagnoses category includes any DSM-identified disorder whether behavioral, developmental, emotional or substance-related.

In the quarter, youth with substance-related diagnoses represented 15.2% of the registered population, a decrease of .4% from the previous quarter. This statistic may not

represent all youth with a substance-related impairment, or the number of youth with substance use identified as a target of intervention. Because diagnostic criteria for substance-related disorders require youth to exhibit a variety of symptoms and impairment, not all youth who use substances or who might benefit from interventions targeting substance use would be diagnosed with a substance-related disorder. Therefore, this statistic, which is drawn from the diagnostic category, is expected to underestimate the total number of youth experiencing a substance-related impairment. Any youth registered with CAMHD that presents in a treatment program with a substance related issue receives treatment services as indicated.

Services

Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. At the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment. Tracking of utilization of the services at the aggregate level allows for accurate accounting, and data-driven planning and decision-making.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (January 2005-March 2005). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

During the quarter, the largest percentages of youth served received services provided in the home and/or community, which consist of Intensive In-Home services (47.8%) and Multisystemic Therapy (MST) (14.0%). The percentages of youth receiving services in these in-home categories decreased by .2% for each of these services over the last quarter's percentages.

Table 6. Service Authorization Summary (January 1, 2005-March 31, 2005).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	7	7	0.4%	0.7%
Hospital Residential	22	34	1.8%	3.4%
Community High Risk	10	11	0.6%	1.1%
Community Residential	118	155	8.3%	15.3%
Therapeutic Group Home	75	96	5.1%	9.5%
Therapeutic Family Home	130	146	7.8%	14.4%
Respite Home	1	2	0.1%	0.2%
Intensive Day Stabilization	0	0	0.0%	0.0%
Partial Hospitalization	0	0	0.0%	0.0%
Day Treatment	0	0	0.0%	0.0%
Multisystemic Therapy	99	142	7.6%	14.0%
Intensive In-Home	406	485	25.9%	47.8%
Flex	110	181	9.7%	17.9%
Respite	25	29	1.6%	2.9%
Less Intensive	59	128	6.8%	12.6%
Crisis Stabilization	5	13	0.7%	1.3%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

The largest group of youth in an out-of-home setting received services in a Community-Based Residential program (15.3%). The percentage of youth receiving these services was slightly down from the previous quarter's (October-December 2004) authorizations

for 16.5% of the registered population. Youth receiving treatment while in Therapeutic Family Homes accounted for 14.4% of those served (slightly up from the previous quarter's 14.3%), and Therapeutic Group Homes 9.5% (up from 9.0% in the previous quarter).

In the reporting period, services paid for through Flex funding were provided for 17.9% of youth served. CAMHD calls services paid through Flex funding "Ancillary Services." These services are a broad category that range from mental health services not provided through a regular purchase of service contract, to travel for youth in off-island residential programs, to interpretive services. They may also include purchase of assessments. Ancillary Services have historically been a key component of the Hawaii system of care, and has allowed for flexible, and often low cost, supports to youth and families. Services are designed primarily to maintain youth in their homes (prevent out-of-home placements) through supports that are not found in the regular array of services. Research has shown that flexible funds are associated with increased capacity of caregivers to provide support and care for their children.

Respite Home services continued to have relatively low utilization with two youth (0.1% of the registered population) accessing this service, which is the same number as last quarter. Again, this service is designed to support caregivers capacities and prevent potential out-of-home placements, low utilization of this service may mean there are barriers to youth accessing this service. This issue is under examination by the Division Public Health Administrative Officer and will be referred to the Utilization Management Committee.

Cost

CAMHD uses several sources to produce information regarding expenditures and the cost of services. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the second quarter of fiscal year 2005 (October 2004-December 2004). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 7. Total cost increases include rate increases that were implemented for most providers in the previous quarter. Out-of-Home residential treatment services in Hawaii, including Hospital-Based Residential treatment, accounted for 82.4% of service expenditures, which is .1% above the previous quarter's percentage of cost. Youth in Out-of-State treatment settings accounted for only 1.4% of total expenditures, which is .2% under the previous reporting quarter's (October-December 2004) proportion of cost.

Table 7. Cost of Services (October 2004-December 2004)

Any Receipt of Services	Total Cost ($)	Cost per Youth ($)[a]	Cost per LOC ($)[b]	Cost per LOC per Youth ($)[b]	% of LOC Total ($)[b]
Out-of-State	150,365	21,481	148,202	21,172	1.4%
Hospital Residential	461,442	13,572	268,435	7,895	2.6%
Community High Risk	422,271	42,227	381,117	38,112	3.6%
Community Residential	4,552,029	27,927	4,237,883	25,999	40.3%
Therapeutic Group Home	2,044,418	22,716	1,882,211	20,913	17.9%
Therapeutic Family Home	2,149,743	15,355	1,890,468	13,503	18.0%
Respite Home	59,004	11,801	2,300	460	0.0%
Intensive Day Stabilization	0	0	0	0	0.0%
Partial Hospitalization	0	0	0	0	0.0%
Day Treatment	0	0	0	0	0.0%
Multisystemic Therapy	868,996	6,163	473,723	3,360	4.5%
Intensive In-Home	1,872,277	4,385	959,300	2,247	9.1%
Flex	3,798,897	22,346	176,319	1,037	1.7%
Respite	127,878	3,456	49,003	1,324	0.5%
Less Intensive	158,504	15,850	12,829	1,283	0.1%
Crisis Stabilization	100,480	8,373	34,960	2,913	0.3%

Note: [a] Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care (duplicated US$). [b] Cost per LOC represents unduplicated cost (US$) for services at the specified level of care.

The cost of Community-Based Residential Services remained the same as the previous reporting quarter. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter had the highest total cost per youth ($42,227 per youth), which has been consistent over time. For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes ($15,355 per youth).

In-Home (Intensive In-Home and MST) and Less Intensive services accounted for 13.7% of the unduplicated cost of services, which is the same as the last reporting quarter (July 2004-September 2004) percentage of total costs for those categories. Youth receiving Intensive In-Home services at some point during the quarter cost an average of $4,385 per youth ($2,247 of which was for Intensive In-Home service expenditures only), which continues to be significantly less than the cost per youth in any residential program.

Youth who received Ancillary Services through Flex funding during the quarter had a cost of $22,346 per youth. These youth most commonly receive other treatment services in addition to those flexibly funded. The total cost for Flex-funded services alone was $1,037 per month. The average cost per youth for a child receiving a Flex-funded service at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for these services suggest that youth in out-of home placements account for a high percentage of youth receiving a Flex-funded service. A high proportion of Flex-funded services are travel costs including family visits when placement is off-island.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for central office and Family Guidance Centers that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed analysis is conducted by CAMHD Administrative Services.

Services for Youth With Developmental Disabilities

Although the Memorandum of Agreement (MOA) between CAMHD and DDD ended in June 2004, the provision of services, supports and coordination for youth with mental retardation and developmental disabilities continued for the target population.

Respite Services

For January, February, March, DDD met respite needs of the target population through the DDD service system. DOH case managers continued with assisting families to access other service options such as DDD Respite (via open enrollment), Home and Community-Based Service—DD/MR (HCBS-DD/MR) waiver program, and other DDD funded supports. The table below shows updated utilization of various DDD services that families accessed to meet their needs.

Table 8. Other Service Options Utilized by Respite Recipients

DDD Service	# of Users
*HCBS - DD/MR Waiver	51
**POS - Partnerships in Community Living (PICL)	5
***DDD Respite	36
****Family Support Services Program (FSSP)	12

* Waiver admission as of 3/31/05
** PICL referrals for period of 1/1/05 – 3/31/05
* **DDD Respite (CAMHD recipients who applied in open enrollment of January 2005)
****FSSP enrolled 1/1/05 - 3/31/05

Table 9. Expenditures to Date for Respite by Island

Island	# Youth Served	% of Total Youth	Total Cost Per Island	% of Total Dollars Expended	Average Cost Per Youth
Oahu	73	55%	$148,303.93	44%	$2,031.56
Hawaii	34	26%	$89,714.00	27%	$2,638.65
Kauai	11	8%	$61,644.50	18%	$5,604.05
Maui	14	11%	$37,358.00	11%	$2,668.43
Total Youth	132	Total Dollars Expended (July 2002 - March 2005)			$337,020.43

While families accessed DDD service options, there were no respite expenditures for the period January, February, and March. The total dollars expended for the target population since July 2002 is $337,020.43.

Residential Services

DDD will be extending the Individual Community Residential Support (ICRS) contract for one year. ICRS currently provides for special treatment facility services for one youth. As reported in our previous report, two out of three individuals who resided in the special treatment facility are now adults and transitioned to DDD's licensed adult foster homes in January 2005. The transition appears to be stable; the DOH case manager is involved to ensure the residential settings and supports for these individuals meet their needs.

All but one individual of the thirteen youth in the original target population receiving ICRS services have been admitted to the HCBS DD/MR waiver program. This

individual continues to receive psychiatric treatment and hospital-based residential services; DDD is now assessing this individual's current residential needs since discharge has been recommended.

Performance Measures

CAMHD uses performance measures to demonstrate sustainability and adequacy of services, results, infrastructure, and key practice initiatives. They measure the ability to maintain gains made since the inception of the Felix Consent Decree, and achieve CAMHD practice standards. CAMHD has set performance goals for each measure. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

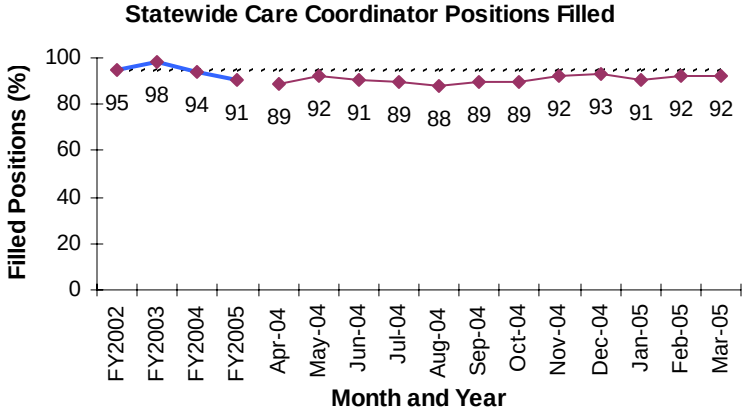
Performance measures linked to previous Court Benchmarks are noted by an asterisk (*).

CAMHD will maintain sufficient personnel to serve the eligible population

Goal:

⇨ *95% of mental health care coordinator positions are filled**

Over the reporting period, CAMHD had an average of 92% of care coordinator positions statewide filled, which was 3% below the performance goal. This performance is slightly above last quarter's average of 90% of positions filled. This quarter's results reflects the sixth consecutive quarter the performance goal was not met since this indicator began to be reported at the start of FY 2002. The primary impact on performance for this indicator continues to be the length of time it takes to fill care coordinator positions within the State personnel hiring process.



The percentage of filled Care Coordinator positions over the quarter for each Family Guidance Center is displayed below.

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KAUAI
100%	90%	80%	100%	100%	88%	90%

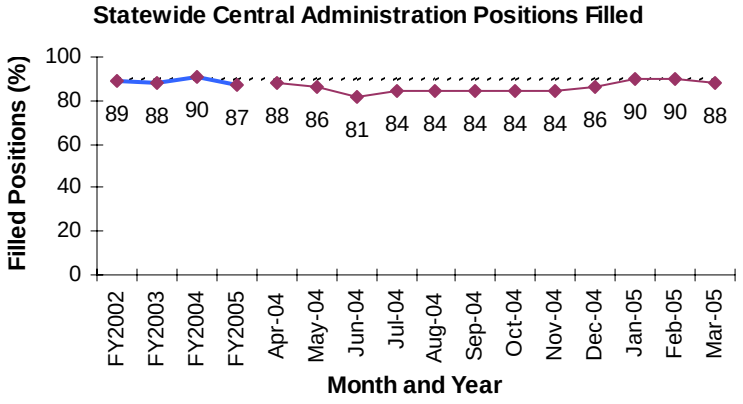
Vacancies in Leeward Oahu, Maui, the Big Island, and Kauai impacted the Statewide average over the last quarter. Each of these FGCs experienced one to two vacancies. Currently, there is one vacancy at LFGC and two on Maui. There are start dates for candidates to fill the vacancies on the Big Island and Kauai.

Goal:

⇨ *90% of central administration positions are filled**

The performance target was just under the desired performance with an average of 89% of central administration positions filled over the quarter. This is below the goal for the fourth consecutive quarter, but above last quarter's performance of 84%. Central Administration positions provide support for the infrastructure and quality management functions necessary to manage the statewide service system.

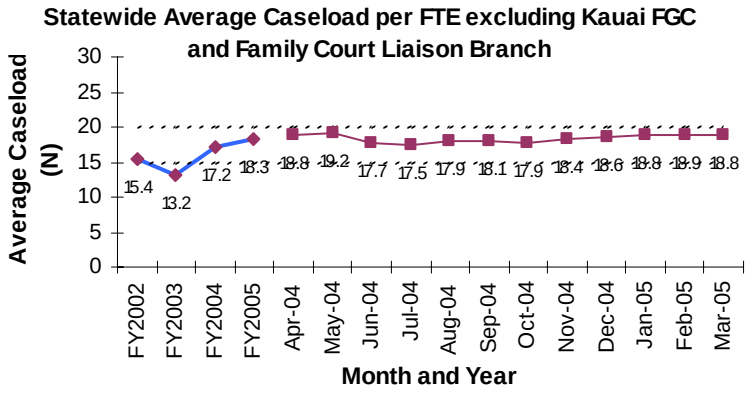
Vacancies across the central administration's offices continue to impact this measure. Most of the vacant positions fall in the Management Information System section, a section that is vital for processing of provider and Medicaid billing, management of information for clinical decision-making, and many other aspects of data-tracking on youth served. The Transition Specialist position in the Clinical Services Office has been vacant for some time due to the inability to recruit a qualified candidate. Several other positions are being filled by temporary hires while permanent personnel are under recruitment.



Goal:

⇨ *Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.*

The statewide average caseload for the third quarter was within the target range at 18.8 youth per full time care coordinator equivalent (FTE), which meets the performance goal for the measure. Each of the three months in the quarter met the performance expectation. CAMHD expects that care coordinator caseloads consistently fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services. Average caseloads have consistently been in the targeted range since the beginning of fiscal year 2004.



The average caseloads performance target was met for all FGCs, except Leeward Oahu and the Big Island FGCs where the caseload was one or two above the expected range. It should be noted that with the exception of Honolulu FGC, all FGC caseload averages were above, or approaching, the upper limit of twenty cases per care coordinator.

Average Caseloads by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
3rd Quarter Average	19	22	17	17	16	21

The calculation of average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads. Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center.

CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight

Goal:

⇨ Sustain within quarterly budget allocation.

CAMHD met the goal for sustaining within its budget. The reporting quarter for this performance measure is October 2004-December 2004, which allowed for closing of the contracted agency billing cycle. The total variance from the budget for the reporting quarter was under projection by $5,710,000. Sufficient funds were encumbered for all expected service costs.

Expenditures in all categories were below budget. Historically, services have accounted for the largest variance, and these expenditures have invariably been below what was budgeted. To date the total variance from the budget for FY 2005 was under projection by $2,830,000. Projections include service dollars that have been or will be encumbered and/or expended in the remainder two quarters of the fiscal year.

Variance from Budget (in $1,000's)

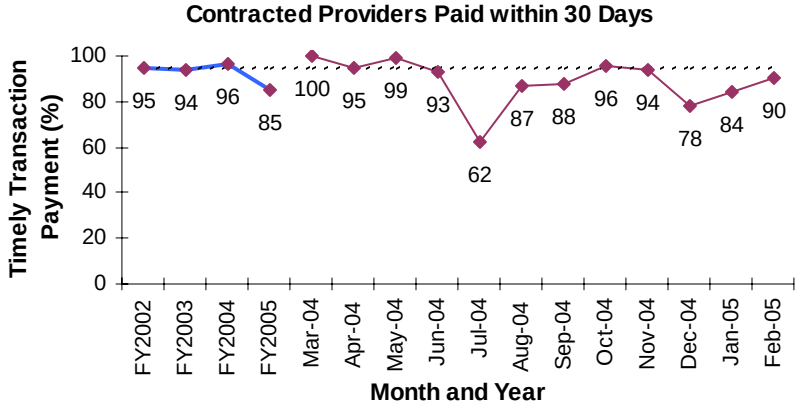
	FY 2002 Average	FY 2003 Average	FY 2004 Average	FY2005 Average	2004.1	2004.2	2004.3	2004.4	2005.1	2005.2
Branch Total	$164	-$150	$20	-$159	$134	$62	-$54	-$60	$20	-$337
Services Total	$798	-$4,175	-$1,849	-$102	$59	-$3,963	-$3,389	-$101	-$2	-$203
Central Office Total	-$189	-$388	-$314	-$22	-$226	-$298	-$344	-$388	-$15	-$30
Grand Total	$773	-$4,713	-$2,142	-$283	-$33	-$4,200	-$3,787	-$549	$4	-$571

CAMHD will maintain timely payment to provider agencies

Goal:

⇨ *95% of contracted providers are paid within 30 days*

Performance for this measure was below target as an average of 87% of contractors was paid within the 30-day window over the quarter. This is a decrease over last quarter's average of 93% of contracted providers paid within 30 days. The data reflect six invoices that were paid beyond the 30-day benchmark, and was impacted by longer than average processing times in the CAMHD Fiscal section and in the Department of Accounting and General Services (DAGS). The CAMHD Fiscal Section has put in measures to expedite the internal claims review and vouchering process and increase the use of a procedure to shorten the processing time through DAGS.



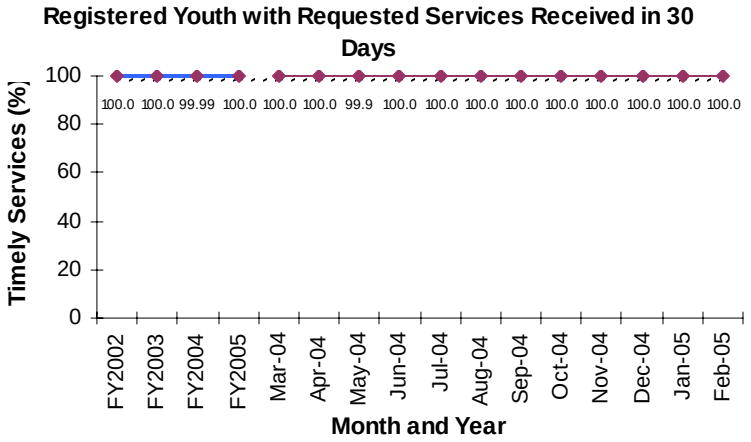
As standard for reporting, the quarter's data is available for the first two months of the quarter (January and February 2005) and includes December 2004.

CAMHD will provide timely access to a full array of community-based services

Goal:

⇨ 98% of youth receive services within thirty days of request*

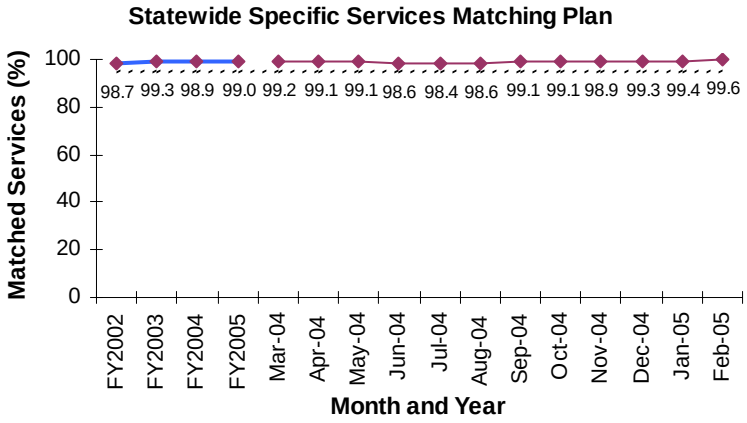
The goal was met for the quarter with 100% of youth provided timely access to services. Data are for the first and second month of the reporting quarter (January and February 2005) as third month data are not available at the time of publication. December 2004 data are included in the average for the quarter.



Goal:

⇨ 95% of youth receive the specific services identified by the educational team plan*

CAMHD continued to demonstrate strong performance on this measure. Over the quarter, 99.5% of youth received the specific services identified by their team plan. These youth received services within 30 days, but they were not the exact service selected by their service teams. Data are for the first and second month of the reporting quarter (January and February 2005) as third month data are not available at the time of publication. December 2004 data are included in the average for the quarter. This measure includes SEBD youth who do not have an educational plan.



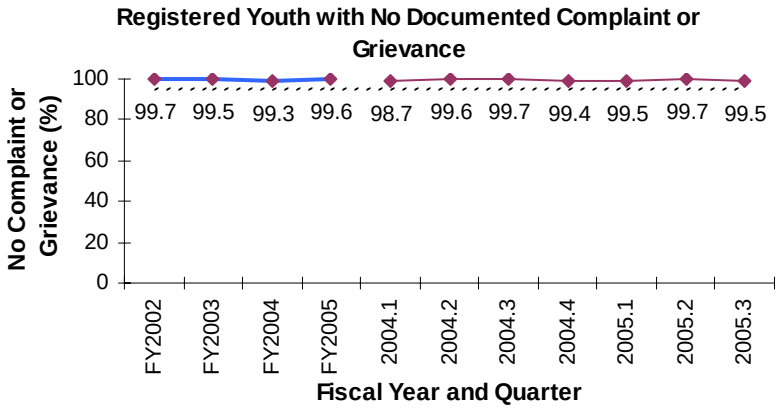
In the quarter, service mismatches occurred in eight complexes versus seventeen in the previous quarter. Campbell Complex was the outlier at four youth receiving mismatched services. Hilo continued to have mismatches for two youth. The remaining complexes experiencing mismatches had one. Pearl City Complex, which had experienced four mismatches last quarter, had one in the current quarter.

CAMHD will timely and effectively respond to stakeholders' concerns

Goal:

⇨ 95% of youth served have no documented complaint received*

99.5% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers. Performance on this goal has been sustained since it was established in June 2001.

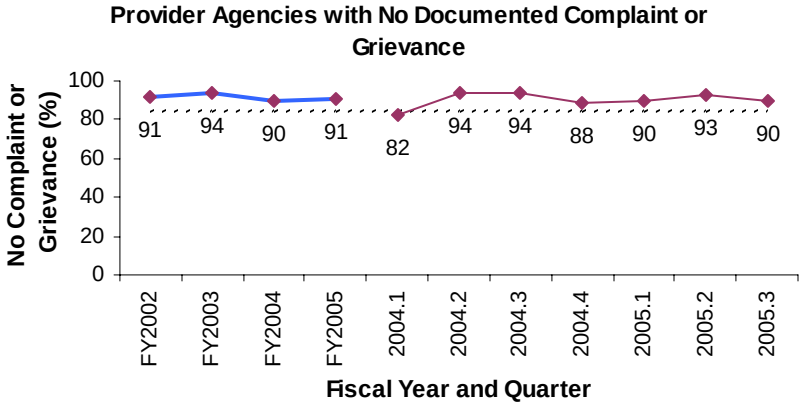


In the quarter, there were complaints received from 10 youth (or someone complaining on their behalf) representing 8 complexes statewide as compared to 5 youth with documented complaints representing 5 complexes last quarter. There was one complaint for each of the following complexes: Waianae, Kaimuki, Maui High, Molokai, and Laupahoehoe. Three complaints were received for youth attending charter schools. There were no noticeable trends in the data.

Goal:

⇨ 85% of provider agencies have no documented complaint received

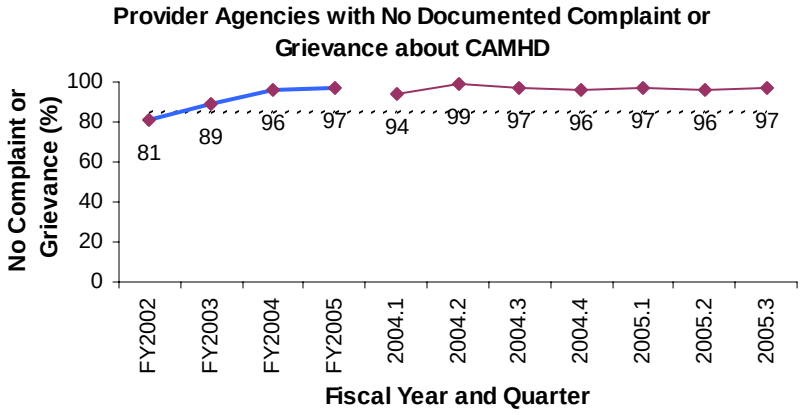
90% of provider agencies had no documented complaint registered about their services, which met the performance goal. The performance target for this measure has been consistently met since the second quarter of fiscal year 2004.



Goal:

⇨ 85% of provider agencies will have no documented complaint about CAMHD performance*

In the quarter, 97% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which met the goal for this measure. This measure has consistently met the performance goal since the beginning of FY2003.

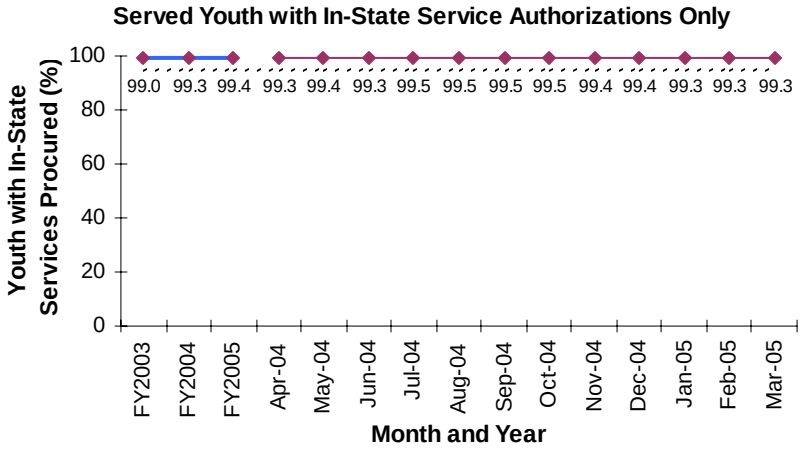


Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting

Goal:

⇨ 95% of youth receive treatment within the State of Hawaii*

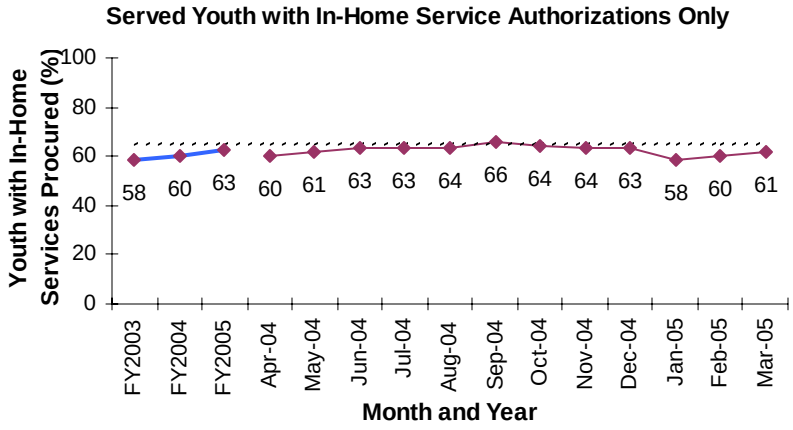
In the quarter, an average of 99.3% of CAMHD registered youth served received treatment within the State, which exceeds the goal. Seven youth received services in out-of state treatment settings in the quarter. These data represent only youth registered with CAMHD who were in out-of-state treatment settings in the reporting quarter.



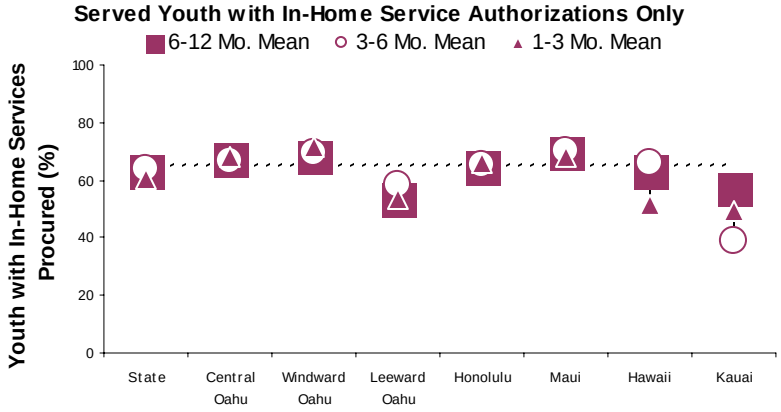
Goal:

⇨ 65% of youth are able to receive treatment while living in their home

The quarter's data showed that an average of 60% of youth were served in their home communities throughout the quarter, which was 5% below the performance goal. The data reflect a decrease of 4% under last quarter's performance.



There was variable performance across the Family Guidance Centers in meeting the goal as can be seen below. The goal was met for Central Oahu FGC (67.8% served in their homes), Windward Oahu (71.5% served in-home), Honolulu FGC (65.6% served in-home), and Maui FGC (68.1% served in-home). Hawaii FGC experienced a substantial decline in performance. This data will be reviewed by the HFGC QA Committee in their next meeting. Kauai FGC improved in this measure since the last quarter due to the filling of a therapist vacancy at the provider agency.



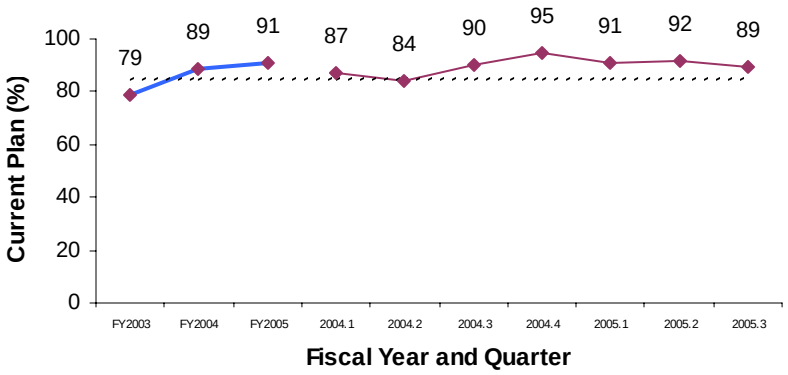
CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

⇨ 85% of youth have a current Coordinated Service Plan (CSP)*

CAMHD's performance in this measure met the performance goal for the reporting quarter with 89% of youth across the state having a current CSP. This was 3% below last quarter's performance. Maui and Windward FGCs did not meet the performance goal in the reporting period.

Average Coordinated Service Plan Timeliness



Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed, but does not include youth awaiting an assessment for determination of SEBD.

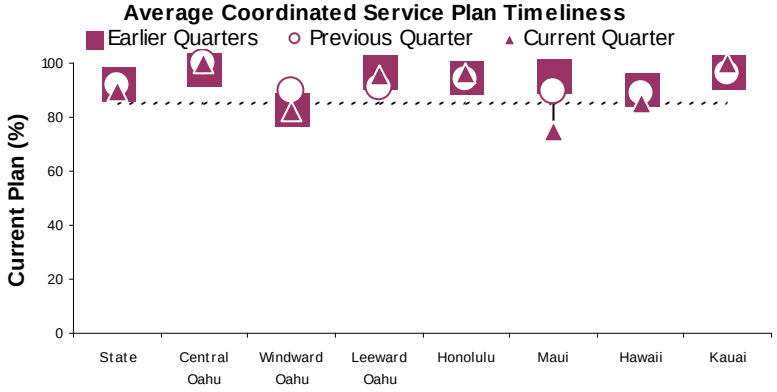
"Current" is defined as having been established or reviewed with the CSP team within the past six months. Quarterly reviews of timeliness are conducted to assess for current CSPs. Registered youth receive an initial Coordinated Service Plan within 30 days of determination of eligibility.

Average CSP Timeliness by Family Guidance Center

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KFGC
100	96	74	82	96	85	100

Trend data for each FGC are displayed below. Timeliness improvements were seen in Leeward, Honolulu, and Kauai FGCs. Hawaii FGC and Windward performance declined slightly, while Maui performance declined substantially due to care coordinator vacancies.

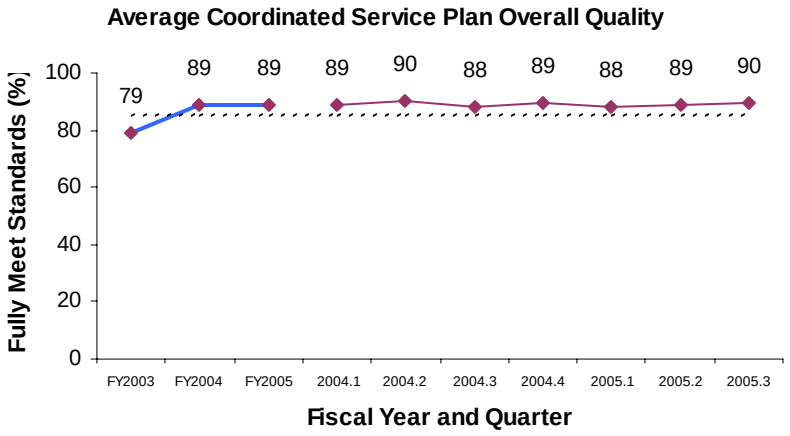
Average Coordinated Service Plan Timeliness



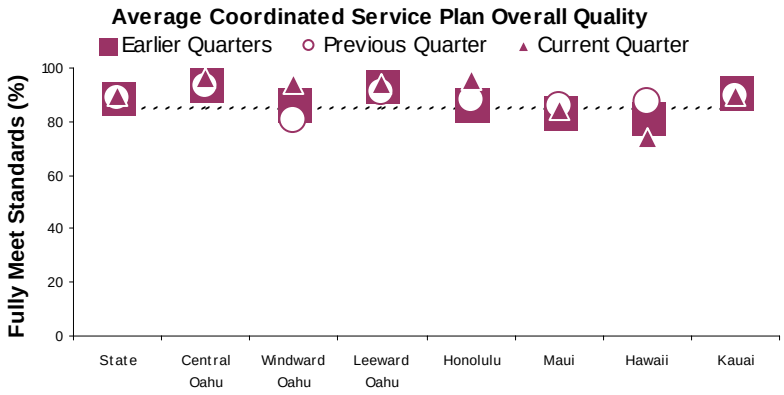
Goal:

⇨ 85% of Coordinated Service Plan review indicators meet quality standards*

The goal for this measure was met in the reporting quarter with 90% of CSPs sampled statewide meeting overall standards for quality. CSPs are reviewed quarterly by the FGCs for meeting standards for effective plans. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and several other key measures. The statewide data for quality of CSPs are displayed below.



As seen in the next chart, the goal was met or exceeded by all FGCs with the exception of Maui and Hawaii FGCs, which declined in performance. Both FGCs will develop specific strategies in their Quality Assurance Committee to address this dip in performance. Central, Leeward, Windward, Honolulu, and Kauai FGCs improved the quality of their coordinated service plans.



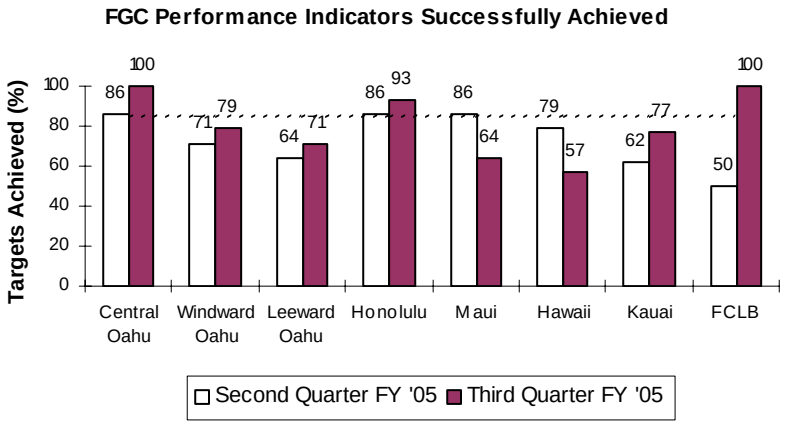
Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ 85% of performance indicators are met for each Family Guidance Center

Three of the eight Family Guidance Centers met the goal. Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: personnel measures, expenditures within budget, grievances, access to services (service gaps/mismatches, least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, and improvements in child status.

The goal of meeting at least 85% of the performance indicators was met by Central Oahu and Honolulu FGCs and the Family Court Liaison Branch (FCLB). Having only two relevant performance measures impacts FCLB's data.



On average across all FGCs, 80.1% of all goals were met in the quarter, compared to 73% in the last quarter, and 67.5% in the previous quarter. Windward, Leeward, Maui, Hawaii, and Kauai FGCs did not meet performance goals. Improvements were seen in Central, Windward, Leeward, Honolulu, Kauai and the FCLB.

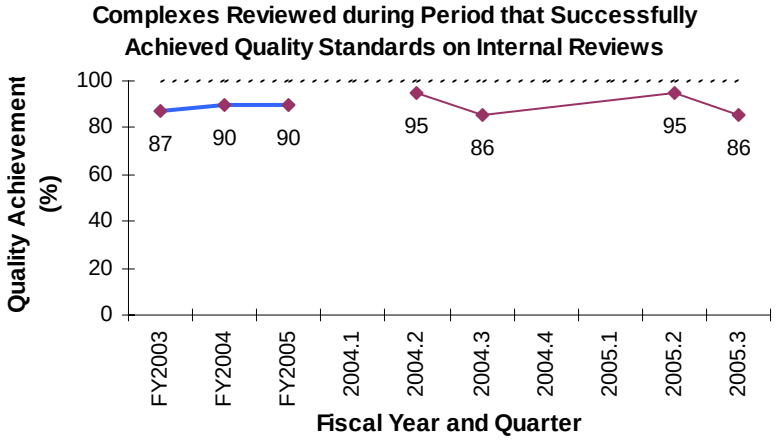
The Family Guidance Centers did well in indicators of maintaining within their budgets, timely access to services, documented complaints from consumers, serving youth in the State, and youth showing improvements as measured by the CAFAS or ASEBA. Generally, the FGCs struggled with filling their care coordinator positions, serving youth while they are living at home, and completing the CAFAS or ASEBA. Several of the FGCs did not meet performance goals for timeliness and quality of CSPs, and achieving acceptable scoring for system performance and child status on Internal Reviews.

Performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed by the FGC internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. The FGC management team tracks the implementation of each improvement strategy.

Goal:

⇨ 100% of complexes will maintain acceptable scoring on internal reviews.*

Of the twenty-one complexes reviewed, nineteen (86%) scored 85% or better on System Performance, which did not meet the performance goal. Three complexes, Ka'u, Baldwin, and Hana, did not meet the goal (for further analysis, see the Internal Reviews section of this report).

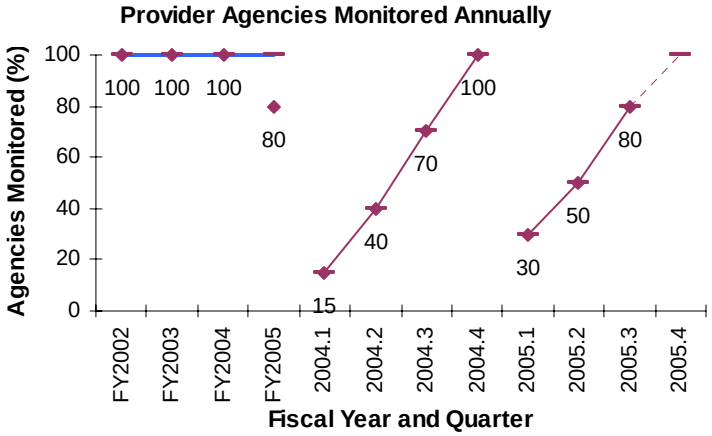


Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ 100% of provider agencies are monitored annually

The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. Thus far this year, 80% of all agencies contracted to provide direct mental health services were monitored as scheduled, which met the targeted goal. Six agencies, representing seven contracts and nine levels of care were monitored in the third quarter.

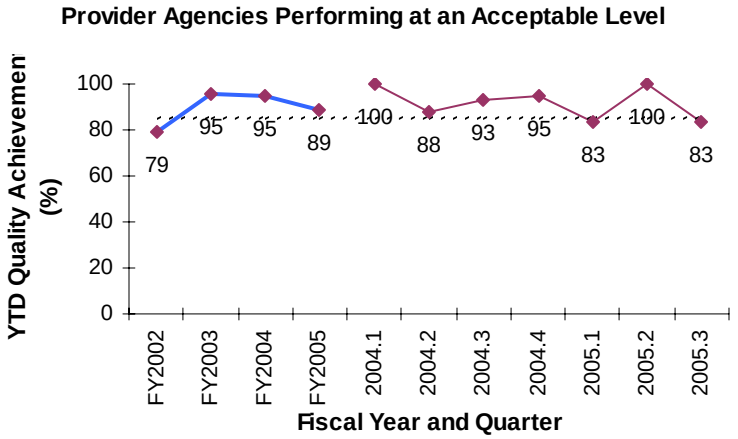


Goal:

⇨ 85% of provider agencies are rated as performing at an acceptable level

In the reporting quarter, 83% of the provider agencies reviewed in the quarter were determined to be performing at an acceptable level, which was slightly below the performance goal. Provider agencies are reviewed across multiple dimensions of quality and effective practices. One agency, at the hospital-based level of care, was found to have a number of issues impacting its overall performance. An improvement plan has been requested of the provider agency.

Currently data for this measure are reported for agencies that underwent the annual performance review in the quarter, and do not reflect the comprehensive and current performance status of all agencies. In the future, this measure will be modified to report performance as percentage of all contracted agencies currently performing at an acceptable level, which will reflect performance status of all agencies.

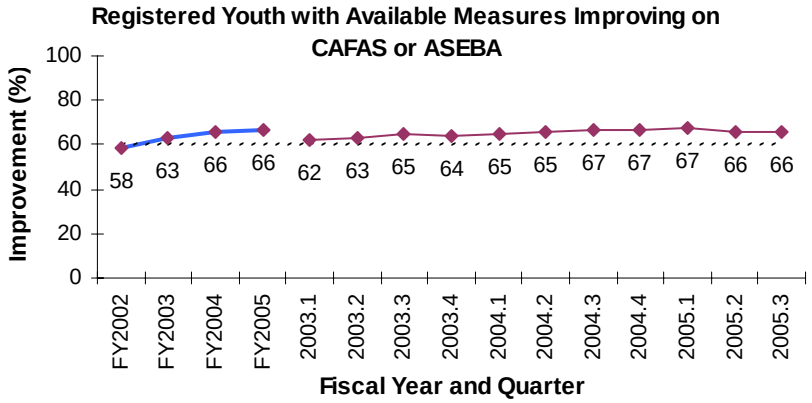


CAMHD will demonstrate improvements in child status

Goal:

⇨ 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA)*

To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to submit the CAFAS and ASEBA for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%.

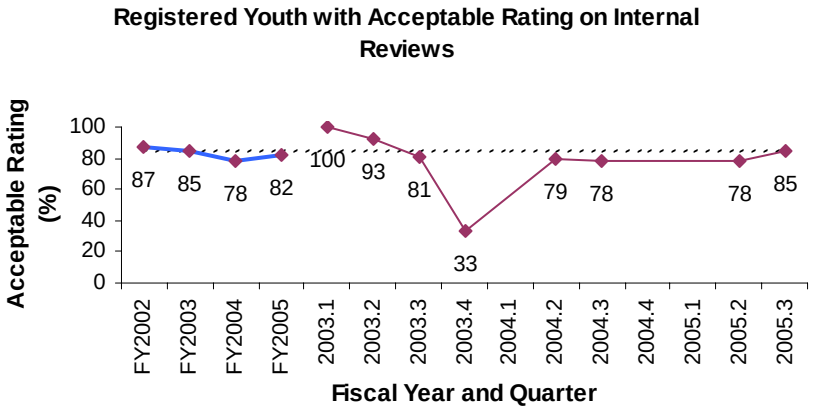


In the reporting quarter, for youth with data for these measures, 66% were showing improvements since entering the CAMHD system, which meets the performance goal. There has been a fairly stable trend in functional improvements for youth served by CAMHD over the past two years. Child functioning as measured by these scales has improved by 8% since the end of FY 2002. This is the second quarter since data have been tracked for this measure in which a slight decline was seen, suggesting that the trend may be leveling off.

Goal:

⇨ 85% of those with case-based reviews show acceptable child status

Of youth receiving care coordination and services through CAMHD, 85% were found to be doing well in measures of child well-being, which meets the performance goal for this measure. This marks the first quarter that child status as measured through Internal Reviews has met the benchmark since October-December 2003.



Families will be engaged as partners in the planning process

Goal:

⇨ 85% of families surveyed report satisfaction with CAMHD services

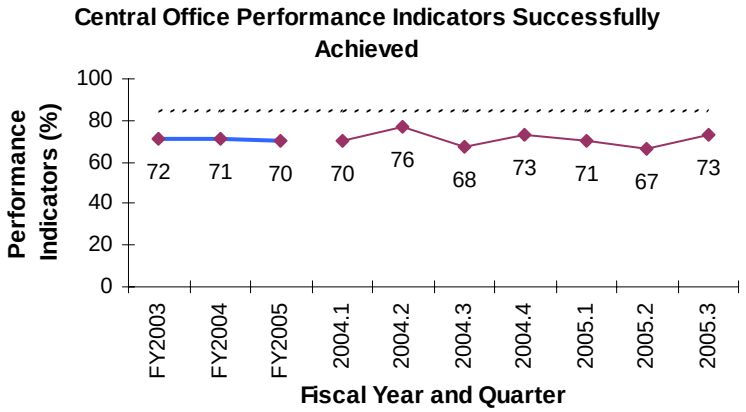
CAMHD now administers the ECHO™ satisfaction survey on an annual basis. The survey builds on widely used instruments for behavioral health care quality assessment, and was designed with the unique needs of populations similar to that served by CAMHD. The next survey will be administered in Spring 2005 and results will be reported in the August 2005 report.

There will be state-level quality performance that ensures effective infrastructure to support the system

Goal:

⇨ 85% of CAMHD Central Office performance measures will be met.

CAMHD's Central Administrative Offices utilize performance measures for each section as accountability and planning tools. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT). There are a total of 37 measures currently tracked by EEMT. Of the 26 applicable measures, 19 or 73% of measures were successfully met in the third quarter, which falls short of meeting the performance goal for this quality indicator, but shows a slight increase over last quarter's performance. The measures that fell below their goals revolved around timeliness and issues related to the impact of staff vacancies.



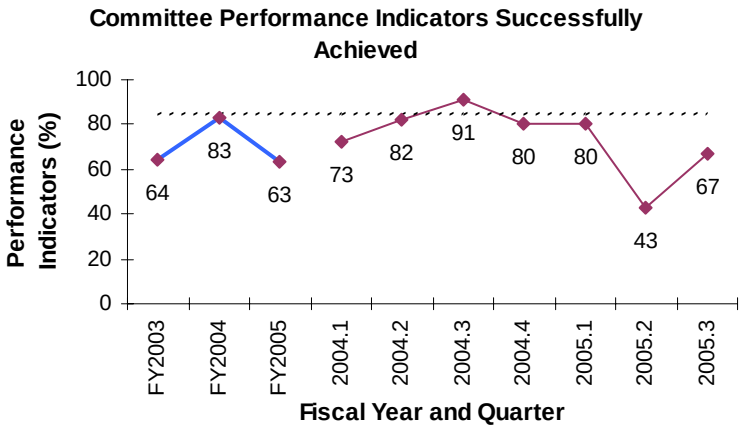
Improvements for Central Office performance measures are managed by respective sections of CAMHD. When solutions require a broader organizational intervention, these are discussed on the regular Expanded Executive Management Team level, and are tracked for implementation.

Goal:

⇨ 85% of CAMHD State Committees performance measures will be met.

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Complaints & Grievance, Compliance, Credentialing, Evidence Based Services, Information System Design, Policy & Procedure, Safety & Risk Management, Training, and Utilization Management. A total of 20 measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in the monthly PISC meetings in order to identify improvement strategies that are implemented by respective CAMHD section managers.

In the quarter, of the 15 applicable measures, 67% were met through the work of the CAMHD Committees, which does not meet the goal for this quality indicator. This is an improvement over last quarter's performance of 43% of measures met. A variety of committee performance indicators did not meet the goal including the committees for Policy and Procedures (milestones met), Information Systems Design (milestones met), Credentialing (timely recredentialing measures), and Evidence-Based Services (article coding and target areas reviewed). Each committee not meeting their benchmark is required to present improvement strategies to PISC.



Summary

The majority of performance goals were met or exceeded in the third quarter of fiscal year 2005 (January 2005-March 2005). The asterisked measures are those linked to historical Federal Court benchmarks. Of these "sustainability measures," indicators met the performance goal in the reporting quarter except for the following measures:

- Two personnel vacancy measures: filled Care Coordinator positions, which was 3% below targeted performance. This measure improved over last quarter's performance as several vacancies were filled.
- Central Administration positions filled, which was 1% below target. Similarly, this measures improved over last quarter's performance as several vacancies were filled.
- Complexes maintaining acceptable scoring on Internal Reviews as three complexes scored below 85%.

The following were measures that met or exceeded goals:

- Care Coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Timely access to the service array:
  - Youth receiving services within 30 days of request*
  - Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns:*
  - Youth with no documented complaint received
  - Provider agencies with no documented complaint received
  - Provider agencies with no documented complaint about CAMHD performance
- CAMHD-enrolled youth receiving treatment within the State of Hawaii*
- Coordinated Service Plan timeliness*
- Coordinated Service Plan quality*
- Monitoring of provider agencies
- Performance Indicators met by the Central Oahu Family Guidance Center
- Performance Indicators met by the Honolulu Family Guidance Center
- Performance Indicators met by the Family Court Liaison Branch
- Improvements in child status as demonstrated by CAFAS or ASEBA*
- Child Status as measured by Internal Review Results

The following measures demonstrated a stable or improving trend, but did not achieve the targeted goal:

- Filled Care Coordinator positions*
- Filled Central Administration positions*
- Contracted providers paid within 30 days
- Performance Indicators met by the Windward Family Guidance Center
- Performance Indicators met by the Leeward Family Guidance Center
- Performance Indicators met by the Kauai Family Guidance Center
- Central Office Performance indicators

The following measures were below targeted performance with observed decreases, and will require implementation of improvement strategies developed by the appropriate monitoring bodies.

- Youth receiving treatment while living in their homes
- Performance Indicators met by the Maui Family Guidance Center
- Performance Indicators met by the Hawaii Family Guidance Center
- Complexes reviewed during the period that maintained acceptable scoring on Internal Review*
- Quality service provision by provider agencies
- State Committees' performance indicators

Satisfaction with CAMHD Services has converted to an annual measure; therefore there are no new data for the following measures:

- Overall satisfaction with counseling or treatment
- Overall satisfaction with company handling benefits

CAMHD continued to experience stable performance in most of the measures associated with sustaining Hawaii's system of care for children and youth with special needs. The three "Sustainability" measures that did not meet desired performance were Complex performance on Internal Reviews (three complex did not meet the performance goal), and two measures for filled positions (Care Coordinator and Central Administration.).

As discussed in the two reports previous to this, vacancies impact the service system across a number of performance areas. The length of time to fill positions, as well as challenges in finding qualified staff are the Clinical Services Office, and the Management Information Systems section. The Clinical Services Office continues to experience challenges in recruiting for the Transition Specialist and two mental health specialists working with federally funded grant projects, impacting implementation of required training and support in designated areas. The Management Information Systems section has had vacancies in two critical data system developers for over a year, which continues to impact the ability of staff to manage this vital area. Without a fully functioning MIS Section, core development and business functions are being impacted and CAMHD is feeling the downstream effects of these vacancies. Specific areas that have been impacted due to these vacancies are clinical information for treatment decision making, information to develop the practice teams and providers of service and insurance reimbursement development.

CAMHD continues to provide services that have positive impact on youth and their families. The factors discussed need to be addressed in order to continue the provision of necessary services.